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PROVIDING CRISIS-ORIENTED AND RECOVERY-BASED TREATMENT IN PARTIAL HOSPITALIZATION PROGRAMS

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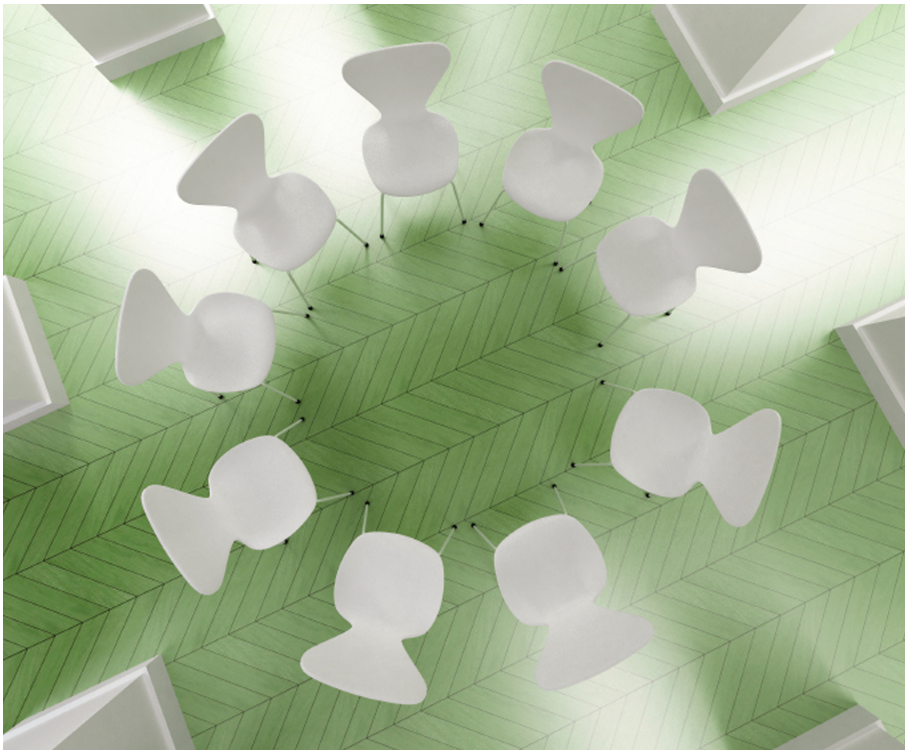
Psychiatry (Edgemont) 2010;7(2):28–31

ABSTRACT

Partial hospitalization programs represent a midpoint along the treatment intensity continuum between an inpatient and an outpatient service. Partial hospitalization programs can be used in place of an inpatient unit for patients who need crisis stabilization and amelioration of their acute symptoms, but who are not imminently homicidal or suicidal. Partial hospitalization programs can also manage adjustments in pharmacotherapy, conduct skills classes, and engage patients in group psychotherapy. In this article, the authors describe the roles and functions of partial hospitalization programs in today's spectrum of psychiatric services and describe the process of transition from an acute inpatient unit to a partial hospitalization programs.



INTRODUCTION

The American Association for Partial Hospitalization (AAPH) defined a partial hospitalization program (PHP) as "an outpatient program specifically designed for the diagnosis or active treatment of a serious mental disorder when there is a reasonable expectation of improvement or when it is necessary to maintain a patient's functional level and prevent relapse or full

FUNDING: There was no funding for the development and writing of this article.

FINANCIAL DISCLOSURE: The authors have no conflicts of interest relevant to the content of this article.

EDITOR'S NOTE: All cases presented in the series "Psychotherapy Rounds" are composites constructed to illustrate teaching and learning points and are not meant to represent actual persons in treatment.

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KEY WORDS: : Partial hospitalization program, crisis oriented therapy, mental health recovery

hospitalization."[1] PHPs are different from day treatment hospital/programs because a PHP provides active and intensive treatment.

Although PHPs can be used in place of an inpatient admission in some cases, they are not a substitute for inpatient care for patients who are actively suicidal or homicidal, because the patients return home at night. Suicidal and homicidal patients require in-patient care, but PHPs can be used as an intermediate step to shorten an inpatient admission.

PHPs also can complement outpatient services. For some patients, PHPs can be used to avoid hospitalization. PHPs are clinically effective for many acutely ill psychiatric patients and their availability can result in more effective use of inpatient resources.[2] Close proximity to and coordination with an inpatient unit can facilitate transition of care and may reduce dropout rates. A location that is close to a medical center or a medical clinic, with access to laboratory services and pharmacy is preferred. PHPs can provide superior or equivalent recovery-based care with greater patient satisfaction as compared to the inpatient treatment, and patients and families were found to be more satisfied with the care one year after discharge as compared with an inpatient discharge.[3]

PHPs can also provide crisis stabilization for patients because patients are able to return quickly to their own environments. PHPs are time-limited programs, which create focused environments that can motivate patients and the treatment teams to invest maximum effort in work of resolving the crisis optimally.[4] While in the PHP program, patients try to resolve their crises, understand their triggers, and try to learn healthy coping behaviors.

BACKGROUND OF PHPs

A Russian psychiatrist, Dzhagaow (1937),[5] first described a partial hospitalization program in Moscow that originated in the early 1930s. PHPs flourished in former USSR during World War II when emergencies of the war did not permit inpatient care of psychiatric patients. Other authors who described partial hospitals include Cameron (1947 in Montreal)[6] and Bierer (1951, in association with the Maudsley Hospital near London).[6] Menninger Clinic also started partial hospitalization programs in the 1950s. PHPs also flourished in the 1970s and 1980s.

Factors that promoted growth of PHPs included the community mental health movement, with its advocacy of locally based treatment settings, and relative cost effectiveness when compared with inpatient care.[7]

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The current "Recovery Movement" in mental health may renew interest in partial hospital programs. The Association of Ambulatory Behavioral Health encourages PHPs to embrace the concept of "mental health recovery,"[8] which is a journey of healing and transformation enabling a person with a mental health problem to live a meaningful life in a community of his or her own choice while striving to achieve his or her own full potential.[9]

In a National Consensus conference on mental health recovery and mental health systems transformation on December 16, 2004, over 110 experts participated and derived a consensus statement. They concluded that there are 10 fundamental components and characteristics of recovery-based mental health treatment which includes the following: self direction, individualized and person-centered approach, empowerment to the individual, holistic approach, being nonlinear, strength-based, having peer support, respect, responsibility, and hope. They emphasized that the recovery-oriented treatment not only benefits the individual but also benefits the society.[9] Recovery-oriented treatment is also encouraged in continued day-treatment programs as well.[10]

COMPOSITE CASE PRESENTATION

Mrs. A was a 45-year-old married woman who was referred from the inpatient unit after she was hospitalized for worsening of depressive symptoms *(composite case, not a real patient in treatment)*. She had made some comments about ending her life and that she would be "better off if her husband killed her and her kids." She had had four previous hospitalizations for suicidal thoughts and depression. While on the inpatient unit this time, she felt supported by the staff and did not feel prepared to be home all day because she felt the environment was "hostile" and she was worried that she would relapse if she was there continually. Her current hospitalization had been precipitated by an argument with her disabled husband, in which he expressed his wish for marital separation.

PRACTICE POINT: TRANSITION OF CARE/STEP DOWN

PHPs can provide continuity of care and a smooth transition from an inpatient unit, reducing the anxiety of patients. In Mrs. A's case, she had met with the PHP's staff while still on the inpatient unit and felt comforted by the PHP staff. Prior to her transfer to PHP it was emphasized that she would need to have specific treatment goals on which to work while in the program,

thus transferring some "ownership" of the care onto her. This facilitated some readiness on her part for change.

COMPOSITE CASE, CONTINUED

Crisis as danger and opportunity. Mrs. A realized that she was going through a crisis in her life that was similar to previous ones that resulted in hospitalization due to suicidal ideation. This time, she was interested in learning about patterns of her crises and how her coping styles could be improved. She also agreed that a crisis was not necessarily "bad" and that it could be "an opportunity for growth."

Mrs. A started coming to the PHP program on a daily basis. She was given information about programming, structure, and expectations. She was "expected" to get better. The program also provided her with structure and behavioral activation, which was lacking in her life.

PRACTICE POINT: STRUCTURE, SUPPORT, AND BEHAVIORAL ACTIVATION

PHPs provide superior social and global adjustment for patients in comparison with inpatient programs.[11] Occupational therapy, recreational therapy, and exercise groups often provide behavioral activation and exposure to other people. A PHP program also provides clinicians with the opportunity to see how the patient behaves in the milieu. Therapy focuses on identifying and gently confronting dysfunctional behavior patterns that may be interfering with the patient's recovery goals.

COMPOSITE CASE, CONTINUED

Goals for recovery. Mrs. A. met with her care coordinator in the program to work on her treatment plan. Her main goals, identified by herself were as follows:

1. "I don't want people to be pushed away by me"
2. "I want to be a good friend."
3. "I need to sort my marriage."
4. "I want to be productive."
5. "I want to get on the right medications."

PRACTICE POINT: EMPOWERMENT AND ENCOURAGEMENT—CONCEPTS OF RECOVERY

Recovery-based PHPs encourage patients to be engaged as partners in their treatment planning. They feel more empowered, knowing that they can make choices. Treatment is strength focused. In Mrs. A's case, she had a strong commitment to her family, which was reinforced through treatment.

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PRACTICE POINT: GROWTH THROUGH EXPERIENCE

Groups in PHPs often provide support, feedback, and insight for patients struggling with interpersonal issues. They often facilitate experiential learning of social skills. PHPs may have unique advantages in the care of patients with personality disorders, offering a favorable level of intensity and containment. It is more effective for patients with personality disorders when compared to standard of care (medication and support).[12]

COMPOSITE CASE, CONTINUED

Learning new coping skills at an emotional level. Mrs. A was able to go through the process in group therapy—anger management groups and assertive training groups—which helped her understand her behaviors, get feedback, and accept her situation. She was able to learn novel coping ways of dealing with interpersonal stressors.

Patients learn novel coping mechanisms at an emotional as well as a cognitive level and the staff and peers encourage them to use these skills in milieu, providing the patients with an experiential learning process.

For example a person who drinks alcohol whenever stressed or in an emotional crisis is made aware of his or her pattern, is confronted about it in the milieu, and is encouraged to seek help or utilize other learned coping behaviors.

Reintegration back into the family and community. Mrs. A reported significant improvement in her mood and anxiety and wanted to go back to her family. She wanted to volunteer at a local hospital and spend time with her family. She became willing to do couple's therapy with her husband.

PHPs also help with reintegrating patients back into their family and community, thus transitioning the care back to outpatient providers.

CONCLUSION

PHPs offer comprehensive intensive treatment focusing on stabilization of acute symptoms. Using a crisis-oriented approach; patients can identify their environmental and personal precipitants, understand their crisis, and learn novel ways of problem solving and coping behavior. PHPs also utilize a recovery-oriented approach, empowering patients to choose options and helping them understand that the recovery is not a linear growth, that it can have ups and downs, and that a temporary move downward is not a "failure." Patients' expectations become more reasonable.

The main common tasks PHPs accomplish are as follows:

1. Engagement in treatment and a smooth transition from inpatient units, into a setting where the patients can be further assessed and treated
2. Crisis stabilization
3. Provision of support, structure,

and behavioral activation
4. Supportive feedback and recovery/empowerment based environment for change
5. Strength-based future planning and continued recovery-oriented work

The lack of clear definition of PHPs and unfamiliarity of these programs often result in underutilization.[13] Not all patients are suitable for intensive PHPs. Grossly psychotic patients and manic patients may not do well in the milieu.[14] PHPs can lay the foundation for further treatment. Engaging patients in treatment planning is a powerful way to ensure recovery in most cases. The patient's personal goals and treatment goals should be periodically assessed. Challenges in meeting their goals are frequently discussed and patients are encouraged to draw upon their own resources in addition to the ones available in the community.

PHPs can provide efficient and cost effective care for many patients who otherwise need inpatient care. PHPs can often avoid hospitalization or shorten the length of stay at the same time proving excellent recovery-oriented care to the patients. It is important to educate clinicians about the benefits of PHPs to increase availability and utilization of PHPs for selected patients.

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